725 E. Main St. Suite 1C
Somerton, Arizona 85350
PH: (928) 627-4525
Fax: (928) 627-4524

FORMER PATIENT INFORMATION DATE:_________________

First Name___________________ Last Name____________________ Middle ______________
Birth date _____________
Phone ______________________________ ( ) cell ( ) home
address____________________________________
____
EMAIL __________________________________

Do you have or have you had any of the following within the past year? (Check any that apply, Circle which eye: R (right), L (left), or Both)

___ Eye injury R L
___ Eye Surgery R L
___ Eye infections R L
___ Discharge R L
___ Itchy eyes R L
___ Burning eyes R L

___ Double vision R L
___ Teary eyes R L
___ Red eyes R L
___ Pain in eye R L
___ Blurry Vision R L
___ Eye Strain R L
___ Headaches

___ Glaucoma R L
___ Cataracts R L
___ Floaters R L
___ Diabetes
___ High blood pressure
___ Cancer

List any medications taking:
____
____

Pregnant/ Nursing ( ) Yes ( ) No

Social History:
Alcohol ( ) Yes ( ) No
Tobacco ( ) Yes ( ) No

Insurance the same ( ) Yes ( ) No

Any changes to make:
____
____
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